quently instrumental compression continued for eight hours were tried without avail. More radical measures were then appealed to and ligation of the left common carotid performed. The results of ligation had been peculiarly happy, and in this case promised well as a prospect of relief if not of cure. "Five weeks after the operation the patient was discharged. At this time the following points were noted: Almost complete reduction of the proptosis. Inability to produce pulsation of the globe. Marked improvement in sight, $V = 0.9$, with $-.75$ Oph. Diminution of the distressing noises and absence of the feeling of distension and discomfort about the orbit."

About four months later the patient returned, presenting himself in about the same condition as when discharged. He was willing to submit himself to further treatment if it were deemed advisable. Further surgical interference, however, was advised against.

Cases heretofore reported in which ligation was resorted to have been recorded as fatal cases or as cures with the exception of one, Roux's case, "in which no effect was produced upon the disease." This last case of Dr. Sattler's may be regarded as one in which, though a positive cure was not effected, very marked relief was afforded.

The future history of this case would be of interest to note as regards the maintenance, advance, or recession of the disease. It is interesting too to speculate upon the effect of tying the right carotid, or injecting what remained of the pulsating tumors with an irritating solution, or of attempting galvano-puncture.

Enough is now known, however, of the effects of compression and ligation for it to be laid down as a rule almost invariable in its application that resort should be had in the first place to the first of these, and, this failing after a fair trial to relieve or alleviate the symptoms, that ligation of the common carotid should be practised. Ligation of the other carotid, galvano-puncture, etc. must depend upon too many conditions that surround each case to permit us to carry the dictum concerning treatment further than this. C. H. C.

ART. XXXII.—*St. Bartholomew's Hospital Reports.* Edited by W. S. CHURCH, M.D., and JOHN LANGTON, F.R.C.S. Vol. XX. 8vo. pp. xxxi., 35, 382. *With an Appendix including Statistical Tables of the Patients under Treatment in the Wards of the Hospital during* 1883. 8vo. pp. xxxii., 35, 382, 97. London: Smith, Elder & Co., 1884.

THE St. Bartholomew's Hospital Reports for 1884 contains a most interesting array of papers, of which those on medical subjects largely preponderate over those strictly surgical. A feature also of this volume is the reprint of an old copy of the *Orders and Ordinances for the Better Government of the Hospital of Bartholomew the Lesse*, which was printed in 1652, and which furnishes very entertaining and instructive reading.

The volume opens with a paper on *The Amount of Carbonic Acid in London Air*, contributed by Dr. W. T. RUSSELL. Whilst the application of this paper is one strictly local, Dr. Russell gives a short description of the methods of analysis, and appends tables and charts which interest the general reader.

Dr. GEE'S *Miscellanies* are also interesting reading. They comprise short notes on such subjects as · 1. A kind of Eczema: Vaso-paralytic? 2. Nervous disorders affecting a whole family. 3. Respiratory croaking of babies. 4. Extreme and fatal dyspnœa in newly born children (which includes the notes of four cases). 5. Idiopathic dilatation of the large intestine.

Dr. ORMEROD presents a paper on *The Later Stages of Hemiplegia*, for which the notes of twenty cases furnish the material—these cases belonging to a class in which the "original lesion was essentially non-progressive," that is in cases of vascular lesion almost solely. Modifications of the exaggeration of tendon reactions are noted, Dr. Ormerod laying down the rule that "in persistent hemiplegia, (1) there appears, after a certain duration of the disease, exaggeration of tendon reactions on the paralyzed side; (2) that this exaggeration is generally the precursor of permanent rigidity." The exceptions which Dr. Ormerod notes in his cases were as follows: In several cases the exaggeration was considerable and prolonged, and yet there was no rigidity; in three cases the tendon reactions were greater on the sound than on the paralyzed side; athetosis was associated with one of these; in one case exaggeration was found in both legs, which the author regarded as a precursor of actual paralysis or (occasionally) contracture of both legs.

The second group of cases includes several in which the hemiplegia was associated with some disturbance of micturition. In one of these cases both patellar tendon reactions were almost absent, and the incontinence was regarded as an early symptom of tabes. One instance of muscular atrophy and several of disorders of movement, ranging from rhythmical tremors to irregular jerky movements, are added. In two cases in this group the spasm "was not constant, but seemed to merge from time to time into a condition resembling late rigidity." The last group comprises eight cases of post-hemiplegic epilepsy. In these cases there is also a wide range, varying from epilepsy to *petit mal.*

The paper is one of great interest, and well worth careful study, as it embraces a discussion of minute examinations which are ordinarily overlooked in practice.

Dr. DUCKWORTH contributes a *Note respecting two Old Specimens of Gouty Arthritis in the Hospital Museum*, and an interesting report of a *Case of Acute Pemphigus in an Adult, fatal on the ninth day*, one-sixth of the whole surface of the body being involved in bullous eruption.

Dr. MOORE discusses the *History of the First Treatise on Rickets*, and gives the priority to Whistler, whose treatise was published first in Leyden in 1645, and afterwards in London in 1684. A photogravure of both title-pages is appended to the paper, and the treatise is described and analyzed at some length.

Dr. VINCENT HARRIS and Dr. DARBYSHIRE contribute short papers entitled respectively *Observations on Anæmia*, and *A Case in which Milk was the Vehicle of the Infection of Scarlet Fever.*

In Mr. SHORE'S paper on *Pericardial Effusion* full notes of three cases are included, and as a conclusion the author advises that exploratory puncture should be regarded as justifiable for purposes of diagnosis "when the physical signs are such as to render the presence of dilated heart improbable, and when the suspected effusion is obviously endangering the life of the patient." In the first case which Mr. Shore records, the diagnosis lay between (1) pericardial effusion; (2) dilated heart; (3) some mediastinal growth, including abscess, lying partially in front of the heart; (4) a localized pleural effusion. By exclusion the diagnosis of pericardial effusion was made, and the puncture confirmed it, but the case, which was a desperate one, terminated fatally during the operation.

Dr. WEST presents *A Few Clinical Observations upon the Action of Pilocarpin.*

Mr. BULLER'S *Inquiry into Some of the Conditions of Abdominal Obstruction, leading to the Conclusion that Rupture of the Intestinal wall tends to take place in one place and in a certain manner*, contains an account of experiments made with large intestines from the post-mortem tables. Twenty-four observations were made, the results of which are contained in tabulated descriptions, and an excellent engraving of a portion of the large intestine, showing a rupture of a longitudinal band, is appended to the paper.

Dr. SHAW presents a paper on *Degradation of Type in the Insane;* and Dr. DAVIES adds to the slowly increasing literature of the subject the report of *A Case of Endemic Hæmaturia from the Cape of Good Hope.*

Dr. KIDD contributes the notes of a case of *Fecal Vomiting without Mechanical Obstruction of the Intestines.* The fecal character of the vomiting is attributed to an "œdematous infiltration of the ileum and the greater part of the jejunum, resulting in a paralytic stagnation of their contents—the peristaltic contractions of the duodenum and upper part of the jejunum ultimately leading to regurgitation into the stomach, there being less resistance in this than in the onward direction."

Dr. LAUDER BRUNTON and Dr. CASH furnish a note from the physiological laboratory, *Why do Medicines sometimes fail to Act?* illustrated by several tables and wood-cuts.

Mr. TOOTH'S paper, *A Case of Epilepsy, with Remarks*, calls attention to several points which were unusual in the case which he reports. One of these was the presence of involuntary micturition during a paroxysm, and the absence of tongue-biting. The former symptom the author regards as essentially an epileptic phenomenon as the latter, though less common, and adds that it is sometimes present when tongue-biting is not. He proposes this as an addition to our means for differential diagnosis in cases where it is difficult to distinguish epileptic from hysterical attacks.

An elaborate paper, *Studies of Microbes at the Biological Laboratory of the Health Exhibition* by THOMAS MOORE, and short contributions by Messrs. COMBES and CHRISTOPHERSON on *Transposition of the Aortic Arch*, and a long and interesting history of the *Hospital Pharmacopœia* by Dr. CHURCH, conclude the papers in this volume, which certainly has the merit of presenting a great variety of subjects to its readers.

A word of commendation of the Statistical Tables for 1883 must be added—they are excellent. R. P. R.

The first surgical paper of this volume is by Mr. JAS. BERRY, *On the Treatment of Cancerous Stricture of the Œsophagus by means of Railway Catheters and Soft India-rubber Tubes*, and is a most valuable contribution. As the measures of treatment he suggests, if they prove equally successful upon further trial, bid fair to do away with gastrostomy except in extreme cases, we shall devote considerable space to the consideration of this paper. The degree of originality in the measures suggested is difficult to determine, and is indeed hardly raised by the author. The germ of the idea was contained in Krishaber's paper, in which he advocated the constant retention of a catheter in the œsophagus, and suggested the possibility that a certain degree of dilatation having been thus effected, ultimately a soft, flexible, rubber tube might be substituted. To Mr. Berry is due the credit of having demonstrated this possibility to be a fact, and simplified and rendered easy of accomplishment this apparently most difficult task. Owing to the corrosion which the catheters underwent, Mr. Croft—a firm advocate of dilatation—advised their change every fourth or fifth day. Mr. Berry points out that, owing to their rigidity, the gum-elastic catheter often gives rise to so much discomfort during the patient's movements as to necessitate its removal and a resort to gastrostomy; in addition, later on, the time will come when an instrument can no longer be passed; and, finally, the risk of perforation is not a theoretical one. To do away with these disadvantages formerly inherent to œsophageal catheterism the author advises "railroad catheters," *i. e.*, those with terminal openings which are introduced over a catgut guide, and when withdrawn the same guide is first introduced through the tube, which is then withdrawn, leaving the guide *in situ*, so that the introduction of the same or a larger instrument is readily accomplished, and the stricture is never without some dilating agent. As soon as a certain degree of patency is effected by the catheters, a soft, flexible tube, cut obliquely at its end, is introduced over the guide and allowed to remain for many days, until by its loose movements when drawn up and down it is clear that a larger one can be introduced. In the method of introducing the soft tubes we must refer our readers to the paper, since to make it clear would require a long explanation. The histories of three cases are fully given, most clearly demonstrating the advantages of the method.

The advantages claimed are, that food can be earlier administered in extreme cases than by gastrostomy, since it will pass by the side of the smallest instrument tied in, when none would before; the difficulty in getting through a cancerous stricture is not its calibre, but the irregularities, fissures, and pouchings which entangle the point of the instruments. Now these difficulties can be just as readily overcome by a small as a large instrument, and "whatever the size of the instrument that is first introduced, we may be sure of being able to replace it in a very short time" . . . . "by one large enough at any rate to allow of the introduction of food." The method, therefore, is especially applicable to strictures of narrow calibre in those who are otherwise condemned either to starvation or gastrostomy.

Strictures of moderate size can often be treated "by the periodical passage of a good-sized catheter;" but, if there is much difficulty in swallowing, which would tend to increase the sacculation of the gullet, food should be taken through the catheter. With a tighter stricture, or one where there exists great difficulty in passing an instrument, a temporary resort to continued dilatation, to be followed by periodical catheterism, is advised. Mr. Berry thinks that there are few if any cases in which perseverance will not enable the surgeon to pass a catgut bougie. "When any difficulty occurs in getting the point of the bougie to pass in the desired direction, I have sometimes succeeded in overcoming it by making the patient attempt to swallow a few drops of water, and by gently pushing the bougie onwards just as the water is being swallowed." In the same way, passing the instrument a short distance during each one of repeated attempts at swallowing, will sometimes enable the operator to hit the opening in the stricture, when the œsophagus is much pouched. In the three cases reported the obstruction was high up in the œsophagus. Whether this method is equally applicable to carcinomatous strictures at the cardiac end of the œsophagus remains to be proved.

The Result in a Hundred Cases of Osteotomy, with remarks by ALFRED WILLETT, forms a most instructive paper, which is replete with points of interest, but which is hardly capable of much further condensation, so that we shall refer to but a few of the more striking statements. Although by far the greater number of cases have been operated upon by McEwen's supracondyloid plan, latterly Mr. Willett has resorted to Reeve's modification of Ogston's, or the intercondyloid method, and says that he must express the decided opinion he has formed, that in the more extreme cases McEwen's plan fails to produce a straight limb. He says that McEwen's operation "in his hands has proved a safe, simple, and certain operation in all ordinary cases of genu valgum or genu varum. That casualties have happened, and some of them even fatal, I am of course aware; but the only events among my own to narrate are, that in Case 17, a very tiny splinter of bone necrosed and came away," . . . . "and in Case 4, a considerable-sized piece of the chisel broke off and was left in the bone—a matter apparently of no moment," as "the after-progress gave no indication of anything unusual having occurred." Full Listerian precautions are invariably resorted to since Mr. Willett experienced deep suppuration in two cases after Adams's operation, death resulting in one. In Gants's, as well as in Adams's operation, the author resorts from preference to the saw by means of which he can make more sure of making section in the proper line. The limb should be put up in an *abducted* position to cause *lowering* of the pelvis upon that side, thus concealing some of the *real* shortening. In operating for curved tibia when dividing the bone in the lower fourth—the usual point—the bone is cut obliquely and the fragments are slipped past one another, this manœuvre, according to Mr. Willett, doing away with any risk of non-union, a possibility which, he says, must not be overlooked when operating upon rachitic cases. Many individual cases of great interest are included in the tables, or commented upon in the "Remarks," and the paper concludes with a "note" by Mr. D'Arcy Power, detailing the appearances presented upon dissection of a case which had been operated on for genu valgum nearly eighteen months previously. Any one interested in this subject should read Mr. Willett's paper in full.

Aural Polypi forms the subject of a short paper by A. E. CUMBERBATCH, wherein he shows that they are—as is well known to those conversant with aural practice—more amenable to proper treatment than the general practitioner is aware of. He shows that their most common origin is from the tympanic cavity; that they arise less frequently in the auditory meatus; and that their most infrequent site is the membrana tympani. His observations teach him that when springing from the mucous membrane of the tympanic cavity they generally arise from its posterior half, whilst those originating in the auditory meatus spring from the postero-superior wall, generally close to the membrana tympani. There is nothing peculiar in his treatment, his preferences being for the removal by forceps or snare of those polypi originating in the tympanic cavity which are large, and touching the spot from which they are removed with a saturated solution of chromic acid, while those projecting but slightly beyond the membrana tympani and those springing from the membrane itself had better be treated only by the chromic acid applications and lotions of boric acid ten grains to the ounce of absolute alcohol, or equal parts of liq. plumbi subacetat. and absolute alcohol. Polypi of the meatus are to be removed and their bases treated as above.

Gastrostomy in Malignant Disease of the Œsophagus, by T. WHITEHEAD REID, Esq., really consists of a more extended history, with the final result, including the post-mortem examination, of a successful case of this operation reported in the *Lancet* for Nov. 3, 1883. The author maintains that "permanent catheterization is applicable to cases seen at a far earlier stage than those now under consideration." Bronchial symptoms contraindicate catheterization, as does, still more certainly, suspected or known ulceration. Beyond this there is nothing in the paper with which our readers are probably not familiar.

A paper entitled *Some Cases of Wounds of the Eye*, by ROBERT J. COLLYERS, contains a number of interesting cases in which conservative treatment was attempted with varying degrees of success or failure, but as this contribution consists only of brief histories of cases, this paper does not admit of a profitable abstract, since no general principles of treatment can be deduced.

The contribution of JAMIESON B. HURRY, M.B., *On Gangrene of Uterine Fibroids followed by Expulsion*, like the preceding paper, chiefly consists of the detailed history of two cases, one of which recovered under the use of very large doses of ergot, while the other, at first doing well, died. In the latter case a small portion of the fibroid was cut off, soon after inflammation followed by gangrene set in, sloughing masses were mechanically removed, and recovery was progressing satisfactorily when at the end of five weeks the patient died of peritonitis and septicæmia.

Mr. W. J. WALSHAM contributes a thoughtful paper called *Notes from the Orthopædic Department, on the Treatment of Lateral Curvature of the Spine.* We cannot do better than give the conclusions at which Mr. Walsham has arrived, premising, however, that we cannot agree with him in his estimate of the plaster-of-Paris jacket, raw-hide supports, etc. No one who has had any experience in the treatment of such cases can doubt that entire dependence on any form of support will result in the evils the writer has called attention to, but still, a plaster-of-Paris jacket properly applied, frequently changed, or sawn so as to be capable of being sprung off and yet be accurately reapplied, *conjoined with* posture-methods and gymnastics, has proven in our hands the best method for the treatment of such cases among the poor. The mistake seems to prevail that a jacket of some kind or other once applied is the end of treatment; with us it is the beginning. Here is not the place to enter into an explanation of what we mean by the "properly applied" plaster jacket, but we may say that it is a modification of Mr. Reeves's plan. The author's conclusions are as follows:—

"1. That all slight cases should be treated by posture and exercises.

"2. That with these some form of bandage or shoulder brace may advantageously be combined.

"3. That the patient should be warned not to trust to either of the last as very efficient means of cure, but only look upon them as useful accessories to the treatment by posture and exercises.

"4. That pronounced cases should at first be treated by posture, exercises, bandages, etc., and only be placed in rigid supports if the former treatment from any cause cannot be thoroughly followed.

"5. That advanced or severe cases in which there is muscular debility may be benefited by posture, exercises, etc., inasmuch as the curves may be prevented

> from increasing, whilst the general muscular strength is improved. But in such little or no improvement of the curves must be expected.
>
> "6. That pronounced and advanced cases may be prevented from getting worse by plaster-of-Paris or felt cases, and may, under some circumstances, be slightly improved.
>
> "7. That all forms of support have a tendency to produce muscular debility, and lead the patient to rely on them at the expense of the muscles of the back.
>
> "8. That even with the use of supports the patient may under some circumstances get worse."

Upon the whole, with the reservations before given, we entirely concur in the author's conclusions.

Extensive Sarcoma of the Vertebræ, Sacrum, Ilium, and Sternum, by H. LEWIS JONES, M.D., is the next paper which we shall notice. All the vertebræ from the fourth dorsal or even higher were effected, besides the sacrum, both ilia, several ribs, and the sternum. The reporter remarks that secondary malignant disease of the vertebræ is usually carcinomatous, while most cases of primary trouble have proven, as his case did, to be sarcoma. Secondary growths seem specially prone to follow scirrhus of the breast. "In women who are or have been suffering from scirrhus of the breast, one should not disregard persistent complaint of pain in the back or legs, especially if there be emaciation as well; and if such symptoms are followed by paraplegia, the diagnosis is almost certain." In one case of Mr. Hawkins, the diseased breast had been removed six years before. The author further says, "The symptoms of cancer of the vertebræ are fairly uniform; first pains in some part of the body, usually in the lower limbs, followed by paraplegia, with pains or painful spasms in the paralyzed limbs." Charcot has described this condition under the name of painful paraplegia, saying that lumbar pains shooting down the legs, nearly constant, although worse at night, and which are subject to exacerbations, and affecting all the nervous ramifications, are the first symptoms. These are followed by a difficulty in walking, which soon amounts to paraplegia, but neither analgesia nor anæsthesia is detectable. According to Charcot, the sphincters are unaffected, but this is certainly not the rule, as, for instance, Mr. Jones's case. The reporter suggests that the site of the disease influences this symptom, and states that in all of Charcot's cases the lumbar spine was involved. Finally, Mr. Jones well says, "It is worth while to bear in mind that there may be, as in the present case, extensive disease of the bodies of many vertebræ, without tumor or prominence of vertebral spines, and angular curvature is as often absent as present." It is interesting to note that a continuous *high* temperature was recorded, which fell to the norm on improvement, to rise again when the pains recurred. This disproves the statement made by some authorities, that rapidly growing sarcomata may be distinguished from phlegmons, etc., by their non-febrile course.

Traumatic Cephalhydrocele forms the subject of a paper by Mr. THOMAS SMITH, in which he relates two supposed cases of this affection. In one death resulted, and a post-mortem examination revealed a large ragged opening through the bone, and no *certain* communication—although the registrar *thought* there was—with the arachnoid sac, much less with the cavity of one of the ventricles, as maintained by Mr. Lucas and Prof. Conner, and as is probably always the case. The post-mortem details by no means demonstrate to us the fact that this was a case such as Conner and Lucas have described, for the tumor contained serum, was bounded externally by the pericranium, and was limited on its deeper surface by the dura mater, but no communication was *proved post-mortem with any of the serous cavities of the encephalon.* The history of the case is by no means conclusive, since with a bony opening of the size described an impulse would be communicated by the normal movements of the brain or in crying, while no mention is made of increased *tension* in the true sense of the word. The other case recovered, *i. e.*, did not die, but the swelling remained. In both instances Mr. Smith considers that the gap in the skull was far too large to have been produced by the injury, and was chiefly the result of absorption. Mr. Bowlby has suggested to Mr. Smith that this absorption was due "to injury to the growing centre of one of the cranial bones, an explanation that would account for the lesion's being confined to young children." Mr. Smith thinks that this affection may be not so uncommon as is generally taught, but that certain cases of unabsorbed cephalhæmatoma are really cephalhydroceles. He is also opposed to any operative interference, and in this opinion we concur.

A Note on the Cause of Pyrexia in Cases of Simple Fracture, and on the Influence of the Nervous System in the Production of Traumatic Fever by ANTHONY BOWLBY, is only another instance of the fact that surgical theories too often work in a circle, and that sooner or later minds of a certain type will become dissatisfied with prevailing theories, and will revert in preference to older ones, since there can hardly be said to be any *really* new ones. We do not intend analyzing in detail the present paper, but shall give some few points which the author holds to be facts. He does not deny that septic changes induce fever, nor the advantages of keeping wounds aseptic, but does maintain that there are other causes. He relates seventy consecutive cases of simple fracture, 8 children and 62 adults, in which temperature observations were made. Among the adults there were only 3 cases in which the temperature did not exceed 98.6° F. In 30 cases the average was 99.7°; in 20 it rose between 100° and 101°, the average being 100.2°; in 9 it was over 101°, the highest temperature being 103°, and the average 102°. The highest point was reached within the first forty-eight hours in almost all cases; in six only did it occur later. In children, strange to say, the least rise took place, the average being 99.2°. Mr. Bowlby says that this fever is really the fever following shock, the old "fever of reaction," and the tension due to extravasated blood is an additional cause. As a proof of the latter factor, he has seen the temperature rise to 102° after the too tight application of a splint to a deformed limb; this can only act, he thinks, through the nervous system. Pain is another element which the author has proved to be capable of raising the temperature from 2° to 3°. "Nevertheless, all pain does not cause pyrexia, but, on the other hand, when excessive, and more particularly when transmitted from organs in connection with the sympathetic trunk, it produces shock and depression of temperature," *i. e.*, renal and hepatic colic, etc. Other points are made in this paper which we cannot devote further space to discuss. If Mr. Bowlby's views are correct, it will certainly prove a great relief to the surgeon's mind to be able to see, in the fever following an operation or traumatism, no *necessarily* septic absorption. In our own observations, we have not found this constant rise of temperature in all cases of fracture, although we have looked for it. It is therefore premature to express an opinion as to the correctness of Mr. Bowlby's views until other observers have corroborated his observations. They are certainly ingenious, and deserving of careful thought and study.

In Mr. EDGAR W. WILLET's communication, called *Cases from Mr. Savory's Ward*, three histories are given, the first being that of a case of fracture of the body of the sixth cervical vertebra, in which the patient survived until the eleventh day, and then the immediate cause of death was "pneumonia with pleuritic effusion."

The second case, one of recovery in a depressed cranial fracture where there were no compression symptoms, is not so unusual as to be specially worthy of record, if the *exact site of the depression is given*, since no motor or other disturbance was to be expected, unless due to secondary intracranial inflammation. In addition, the external table was considered to be the only one involved. The depression was at the anterior and lower part of a wound which was situated over the junction of the left parietal and temporal bones. This would certainly escape, according to Charcot and Pitres, Champonnière, etc., anything *perhaps* but the speech and facial centres, and from the description, the fracture ought to have been below these points. A case of intussusception twice reduced by the injection of warm milk, it seems to us—in view of other histories, post-mortem and ante-mortem—should read "almost completely" reduced at the first sitting, and completely at the second; recovery took place.

G. B. FERGUSON, M.D., describes and figures a *Mode of Cyst Formation in the Mammary Gland*. He considers that in his section "the exuberant gland tissue is caught, as it were, in the very act of forming cysts." It is rather difficult to render his explanation of the section clear without the cut, and we are not at all certain that many practical pathologists were not familiar with the appearances described, although it is true no writers have specifically described them; but, lest any injustice be done, we shall quote his own words:—

> "Firstly, there is a cellular proliferation whereby an acinus is somewhat closely packed. There often ensues expansion of the acinus, with internal production of papillomatous cellular ingrowths, until the external wall condensing more and more, and the cells gradually restricting themselves to two or three layers on the internal wall (the remaining cells having probably coalesced to form the mucous contents), at last a perfect cyst is formed."

From the abstracts of the surgical papers of this volume which we have given, it will be admitted that while they are all of interest, but few of them seem likely to be of very permanent value. C. B. N.

ART. XXXIII.—*The Student's Guide to Medical Jurisprudence.* By JOHN ABERCROMBIE, M.D., Cantab. M.R.C.P., Lecturer on Forensic Medicine in the Charing Cross Hospital Medical School, etc. 12mo., pp. 387. Philadelphia: P. Blakiston, Son & Co., 1885.

THIS little volume is, we believe, the latest aspirant for professional favor in the domain of forensic medicine, a department that has within the last few years been unusually prolific in works of this character, intended more especially to claim the attention of the medical student to what should be regarded as a most important and indispensable branch of his studies, but which has hitherto been almost universally neglected in this country.